velatura
Health Information Exchange

Request to Opt-Out

September 2022

Please read and understand each of the following statements:
Signing this request means that my doctors and caregivers will NOT be able to see my electronic health records through Velatura HIE Corporation (Velatura) even in the event of an emergency. This "Request to Opt Out" cancels any written consent to share my health records with Velatura that I completed before this date; however, my health care team is not required to remove any of my health records that were shared with them before this date. I may choose to join Velatura again at any time by signing an "Authorization and Consent" form. I am signing this form because I do not want my health records shared with my doctors and health care team members through the Velatura network. It may take 2-5 business days after receipt, to process this Opt-Out form and to prevent the sharing of my health information through the Velatura HIE.

Patient Information:
First Name:_____ Last Name: _____ Middle Name:_____ Other Name: _____ Birth Date:_____ Gender:_____ Phone:_____ Social:_____ Address:_____ City:_____ State:_____ Zip: _____ Email Address: _____
X_____ Date: _____

This area is to be completed by a Notary Public

The foregoing instrument was acknowledged before me, a Notary Public, on _____(date) by _____(patient name), known to me to be the person whose name is subscribed to the within instrument & acknowledged that he/she executed the

Notary Signature:_____ State:____ County:

Submission Instructions:	Notary Stamp:
Mail To: Velatura HIE Co PMB 270 2000 East Broadway Columbia, MO 65201	